RECAPTURING EXCESS FEDERAL COSTS USING A HIGH COST PLAN ASSESSMENT

1. There are no premium caps. Health plans may charge whatever price results from a more competitive market.

2. To protect the federal budget from the risk of higher premiums, excess federal costs are recaptured through an assessment on high cost health plans.

   The assessment serves two purposes: To maintain budget neutrality, and to exert downward pressure on premiums.

   (The federal budget is at risk for subsidy payments and tax revenue loss resulting from higher premiums. Higher premiums could be caused by windfall payments resulting from universal coverage -- particularly in the short term -- or by a failure of competition to bring down premium increases over time.)

3. The assessment on high cost plans could work as follows:

   a. It could be applied only in states (or substate areas) where competition is ineffective. It is triggered automatically in a state if the average premium exceeds the "target premium" in that state.

      The target premium for a state (or substate area) is based initially on current health care costs, but with added funding for the uninsured and assuming no windfall for providers or insurers. The target premium grows from year to year at pre-established rates based on reasonable expectations for a more competitive health care marketplace.

   b. It could be structured in a variety of ways. Two options are:

      i. The assessment for a health plan is X% of the difference between the plan's premium and the target premium.

      ii. The assessment is applied to a plan's entire premium, but the percentage assessment rises by Y percentage points for each dollar the plan's premium is above the target premium.

      (Note: After the first year, the assessment could be applied based on a health plan's rate of growth instead of its premium relative to the target premium.)

   c. The assessment could be applied after the fact (i.e. lagged a year) or set prospectively based on bids from health plans.

   d. The assessment could be administered as a tax, or as an offset to payments to health plans (assuming there is a premium clearinghouse or reinsurance pool of

some kind).

If administered as an offset to payments to health plans, the assessment would in turn be used to offset federal subsidy payments to the state (or substate area).

e. The percentage assessment is set nationally each year, and is calculated in order to recoup excess federal costs. While the same assessment percentage applies everywhere, it is triggered only in areas where competition is ineffective. If the assessment raises too much or too little revenue to recapture excess federal costs, the percentage is adjusted accordingly in the following year.

4. The assessment would apply to community rated plans, but could be broadened to experience rated and self-insured plans as well (with some modifications).

Langua (how to sell)

Model Assumptions:

500 ✓

250 ✓

- perhaps alternative baseline premium or one less for currently uninsured.

5 year Subsidy Savings Decomposed

Overall 5 year subsidy savings of Kennedy Mark vs. HSA		**21**
Better Targeting (individual wage cap vs. firm payroll caps)		**26**
More Generous Household subisides		**- 27**
Self-employed, nonworkers, and part-time workers	**-16**	
Workers in firms outside the mandate	**-11**	
Employer subisidy savings from the ≤ 5 worker exemption		**13**
2% Lower Premiums		**9**

1
PRELIMINARY STAFF ESTIMATES AFTER CONSULTATION WITH CBO AND THE ADMINISTRATION.

Post-it™ brand fax transmittal memo 7671 | # of pages ▸

To Chris Jennings	From Ken Nichols
Co.	Co.
Dept.	Phone #
Fax #	Fax #

GROWTH RATE PROJECTIONS
Fiscal Years

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
CPI	3.0%	2.6%	3.1%	3.3%	3.3%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
Nominal Wage Growth		5.0%	5.6%	5.6%	5.6%	5.5%	5.5%	5.2%	5.4%	5.6%	5.6%	5.6%	5.6%

Midsession review; June 1, 1994

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL
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To CHRIS/CATHY
From KEN
Dept./Agency
Phone #
Fax # FYI
Fax #
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

SUMMARY

1. Overview:

No mandate

Phased-in individual based subsidies

tax on high cost health plans

Hard cap on Federal health spending

Pros	Cons
Starting small allows time to learn about how to manage insurance reforms	Won't get universal coverage
Solid fail-safe protection for the Federal budget	Very little private sector cost-containment
Subsidies are targeted very well to low income households	Premiums in the community rating pool are likely to be high due to adverse selection; subsidies might not be large enough to cover these higher premiums.
Minimizes job losses	Medicare program savings and no expansion of benefits to the elderly
Incentives are improved for insurers and patients	

2. Coverage/Insurance Reforms:

No mandate, but firms of 100+ must offer plans.

2 kinds of groups: age adjusted community rated (limited to firms of < 100 and individuals) and experience rated (for all other groups).

Voluntary purchasing pools for individuals and small businesses with 100 or fewer employees with community rating.

Individuals and small groups could also join FEHB plans but would pay the community rate.

Groups of firms under 100, (MEWAs), are grandfathered into their right to receive experience rating.

Firms with more than 100 workers will be experience rated or self-insured.

Guaranteed renewability and limits on pre-existing condition exclusions.

If 95% not covered by 2002, National Health Commission meets to make (nonbinding) recommendations to Congress on achieving universal coverage.

3. Subsidies:

Once eligible, those below 100% of poverty receive a voucher equal to the average premium price in a geographic area.

Once eligible, those between 100-240% receive a sliding percentage of the average premium price.

Subsidy eligibility phased-in -- from 90% of poverty in 1997 to 240% in 2002, IF financing allows.

No cost-sharing subsidies.

4. Benefit package:

One standard (equal to FEHB's BCBS standard) and one basic (catastrophic)

Under 200% of poverty cannot use subsidies for basic plan

5. High cost plan assessment:

Within each group of plans (community rated and experience rated/self-insured) the highest priced 40% are taxed.

Tax rate is 25 percent of difference between the average premium in that group and the plan's premium.

6. Medicaid:

Preserved as a separate program and beneficiaries are not part of the community rating pool.

State option to enroll limited numbers of Medicaid cash (AFDC & SSI) into private health plans.

Growth in Federal payments is capped.

Disproportionate share payments are phased out by 2000.

7. Medicare:

Program savings smaller than HSA, but most of same proposals.

Includes Durenberger bill proposals that push harder for greater HMO enrollment.

No Medicare drug benefit or new long term care program.

8. Other Federal Programs

FEHB remains as is, but those eligible for community rating pool are allowed to join.

Indian Health Service, Veterans' health care, and DoD apparently unaffected.

Outline refers to initiative to improved access in underserved areas through increased resources for community health centers. Specific proposals are unclear, however.

9. Tax incentives:

Phased in deduction of health insurance premium payments for individuals.

Deduction limited to average premium in each group.

10. Financing:

Fail-safe mechanism funds subsidies only as other Federal health savings become available

Medicaid and Medicare savings

Cigarette tax increased $1 per pack

Assessment on high cost plans

Postal Service savings

Medicare HI tax levied on State and local workers

Long Term Care tax advantages and inheritance taxes are made more generous

Fiscal Summary

Changes from Baselines

($ Billions)

	1995-1999	1995-2004
Outlays		
Low Income Voucher Program	217.3	613.6
Medicaid	72.4	268.9
Medicare	77.3	252.3
Other Federal Health (1)	13.0	13+
Revenues		
Tobacco tax (2)		
High Cost Plan Assessment		
Tax Expenditures		
Other Revenues		
Net Deficit Effect	54.6*	79.4*

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

(1) This includes FEHB and Postal Service Effects included in the proposal. Because of insufficient information, it does not include an estimate of the proposal's effects on the PHS or the cost of administering the vouchers. The proposal does not appear to affect VA, DOD, or the IHS, so no spending change is estimated.

(2) This assumes a $1 per pack cigarette tax starting in 1995.

Year by Year Analysis of Low Income Voucher Program ($ Billions)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline										
Medicaid	96.4	108.2	121.5	136.3	152.2	170.4	190.8	213.6	239.1	267.6
Medicare	158.1	176.0	194.0	213.1	235.5	260.8	289.1	321.1	357.0	397.9
Tax Expenditures										
Baseline Total										
Reform										
Low Income Voucher Program	0	0	30.2	49.5	62.4	75.2	87.0	96.3	103.2	109.9
Medicaid	96.4	105.6	114.0	123.0	132.0	141.6	155.2	170.0	186.0	203.4
Medicare	157.7	172.8	186.3	202.1	214.5	226.8	256.4	281.4	309.6	342.7
Tax expenditures										
Reform Total										
New revenues Tobacco High Cost Plans										
Net Expected Surplus or Shortfall	-0.4*	-5.8*	15.0*	25.2*	21.2*	12.4*	18.7*	13.0*	2.7*	-9.6*
Total Uninsured (mil.) (% insured)	40.9 (84.5%)	41.4 (84.4%)	32.9 (87.7%)	30.3 (88.8%)	29.3 (89.3%)	29.4 (89.3%)	29.9 (89.2%)	30.4 (89.1%)	31.0 (89.0%)	31.4 (88.9%)

STAFF ESTIMATES. PRELIMINARY AND UNOFFICIAL.

ISSUES AND POSSIBLE SOLUTIONS

1. Coverage:

Issues	Possible Solutions
Many remain without coverage, perpetuating uncompensated care and cost-shifting to the privately insured.	Add a triggered employer and/or individual mandate.
Premiums will be high in the community rating pool due to adverse selection.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Can still preserve voluntary nature of purchasing cooperatives.
Some moderate-sized firms will be vulnerable to bad experience rating.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.

2. Subsidies:

Issues	Possible Solutions
Subsidy schedule produces very high marginal tax rates.	Smooth it out by having the poor pay something.
Pegging the vouchers to the overall average (experience rated pool plus community rated pool) in a geographic area means that very low income individuals will have difficulty affording plans in the community rating area.	Tie the subsidies for each type of pool to the average premium in that type of pool.

3. Benefit Package:

Issues	Possible Solutions
Offering a basic and a standard package will lead to adverse selection and uncompensated care.	Limit access to basic plan to those above specified income levels (250% of poverty, for example).

4. High Cost Plan Assessment

Issues	Possible Solutions
Assessment is likely to fall on plans with a sicker than average enrollment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers.
Little revenue will be raised from the assessment.	Enlarge the community rating pool to include firms with less than or equal to 1000 workers. Also, have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.
Assessment is unlikely to lead to significant cost containment in the private sector.	Have assessment rate apply to a larger base, for example, to the difference between the premium and a target, where the target is set below the mean.

5. Medicaid:

Issues	Possible Solutions
Limitation of Federal payments while leaving Medicaid program and obligations largely as in current system, places states at risk.	Integration of Medicaid program into larger reform. For example, non-cash assistance recipients could be treated as other low income families.
Disproportionate Share Hospital payments phased out faster than uncompensated care is eliminated, which could have adverse impacts on teaching hospitals.	Tie DSH phase-out to decrease in the number of uninsured.

6. Medicare:

Issues	Possible Solutions
Proposal includes Medicare program reductions, but no benefit expansions.	Phase-in Medicare drug benefit as savings allow.
7% growth target could lead to across-the-board reductions. Unclear if included in final proposal. This could lead to increased cost-shifting to the private sector.	Develop specific policies for reduction in spending.

7. Tax Incentives:

Issues	Possible Solutions
Tax deductibility for individuals tied to the average priced plan in a geographic area penalizes those in plans with adverse selection.	Tie tax deductibility limits to average of plans in that individual's particular pool.

8. Financing:

Issues	Possible Solutions
Financing will be insufficient to fully fund subsidies on a year by year basis, limiting the expansion of subsidies to more income groups.	Broaden the measure of full financing from a year by year metric to a multi-year (3, for example) metric. Alternatively, other sources of increased revenue could be introduced.

COVERAGE OF PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

PROPOSAL: To expand coverage under Part B of Medicare to include outpatient prescription drugs. Those beneficiaries not receiving outpatient prescription drug coverage through a private retiree health plan with coverage substantially equivalent to drug coverage under this proposal would have three coverage options available to them:

1.) individuals receiving care through health maintenance organizations (HMOs) would have their coverage enhanced to include outpatient prescription drugs;

2.) the Health Care Financing Administration (HCFA) would make outpatient prescription drugs available through contracts with approved drug benefit carriers (DBCs); and

3.) HCFA would offer a fee-for-service (FFS) option.

EFFECTIVE DATE: January 1, 1998.

RATIONALE: The Medicare program, and Medicare beneficiaries, could greatly benefit from improved beneficiary access to outpatient prescription drugs. Drugs are an essential part of any integrated approach to patient care, and help to ensure that cost-effective, appropriate care is administered. Studies have shown that appropriate use of prescription medications can greatly reduce health care costs, reduce unnecessary adverse effects and hospitalizations, and improve the quality of life. Senior citizens should be afforded the same health security that is provided to other citizens.

PHARMACEUTICAL COVERAGE THROUGH DRUG BENEFIT CARRIERS (DBCs)

HCFA would contract with various types of pharmaceutical provider groups within each state which would be designated drug benefit carriers (DBCs). There would be no limit on the number of

contractors in each state.

HCFA, in consultation with appropriate individuals and organizations, would develop standards for DBCs similar to those under the Medicare HMO risk contracting program and other standards which would be available one year prior to implementation and which would address:

- Access to community pharmacies;
- Drug utilization review (DUR) and pharmacy care services requirements;
- Formulary structure (definition of major indications, minimum requirements and procedures for a physician obtaining coverage for a drug not on the formulary);
- Beneficiary safeguards in regard to use of prior authorization;
- Compliance programs;
- Procedures for out-of-area claims;
- Financial requirements;
- Quality and minimum commercial enrollment standards.

DBCs would be required to provide access to a pharmacy in every community throughout the state. In addition to the state-wide pharmacy network, mail-order purchase could be offered by plans as an option to enrollees.

As under the Medicare HMO program, a DBC contractor could restructure the beneficiary deductibles and copayments specified in the fee-for-service option to create incentives to participate in its plan. However, the actuarial value of the plan's premium and cost-sharing requirements could not exceed 95 percent of the actuarial value of the deductible and coinsurance under the FFS drug coverage option.

Plans would be prohibited from having differential cost-sharing based on the therapeutic class of drug prescribed or other cost-sharing structures that would be likely to discourage enrollment by individuals with medical conditions that require extensive use of prescription drugs.

One year prior to beginning coverage, HCFA would develop a payment methodology based on expected costs of the FFS option. Payments to DBC plans could be discounted to take into account savings generated by use of formularies and pharmacy networks.

MEDICARE FEE-FOR-SERVICE (FFS) PHARMACEUTICAL COVERAGE

HCFA would establish and administer (or contract with outside entities to manage) FFS coverage of outpatient prescription drugs for Medicare beneficiaries similar to provisions in the Health Security Act. An annual deductible of $350 would be imposed, with a 20 percent copayment charge per prescription. The beneficiary annual out-of-pocket limit would be $1,000.

To manage pharmaceutical costs under the Medicare FFS outpatient drug program, single source and innovator multiple source drugs would pay a rebate of 15 percent off the Average Manufacturer's Price (AMP) for the quarter. AMPs could not increase faster than the increase in the CPI-U for the quarter.

Non-innovator multiple source drugs (generics) would pay a rebate of 10 percent only if their AMP for the quarter was greater than 50 percent of the AMP of the innovator multiple source drug for the quarter. Drugs manufactured by firms that have less than $_____ in sales and do not increase the price of their products faster than the CPI-U for the quarter are exempt from rebate payments.

The Secretary of HHS would have the authority to negotiate the rebate amount for a new drug with the manufacturer (higher than the 15 percent minimum), and exclude the drug from Medicare coverage or require prior authorization for the drug if an agreeable rebate is not established.

The Secretary of HHS shall establish a program of drug utilization review (DUR) consistent with standards established under section 1927(g) of the Social Security Act. The Secretary shall establish a National Drug Use Review Board which shall monitor the quality of pharmaceutical care provided to Medicare beneficiaries under the FFS, HMO, and DBC outpatient prescription drug programs.

ESTABLISHMENT OF PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

The Director of the Office of Technology Assessment (OTA) would establish a Prescription Drug Payment Review Commission (RxPRC), which would consist of 11 members. RxPRC would be responsible for making an annual report to Congress on the operation and implementation of Medicare prescription drug coverage programs, and including recommendations to Congress on changes to the programs to improve access to prescription drugs, the quality of prescription drug care, and program efficiencies.

PAYMENTS TO PLANS FOR DRUG COVERAGE

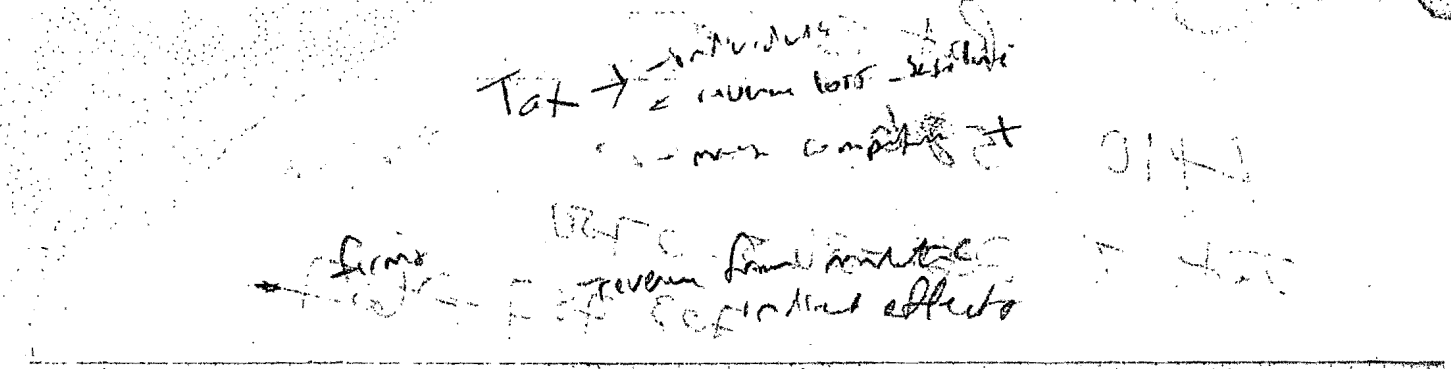
Part B Medicare beneficiary premiums would be increased to cover 25 percent of the drug coverage program costs. Medicare would cover 75 percent of the costs of providing drug coverage.

PHARMACY CARE SERVICES

Each plan, including the FFS plan, shall develop a schedule of services provided by pharmacists that shall improve the quality of care provided to Medicare beneficiaries. These services shall include: counseling of patients by the pharmacist, reviewing the appropriateness of the prescription, checking for therapeutic duplications or drug interactions, monitoring patients that are at risk for drug-related problems, and other tasks consistent with the practice of pharmacy. HCFA and the plan or its contractee shall establish a schedule of payments for such services.

ELECTRONIC CLAIMS PROCESSING

The Secretary of HHS shall establish an electronic claims processing system as the primary method to determine coverage, eligibility, adjudication, and payment of claims under the FFS program.



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STATEMENT BY SENATOR BOB GRAHAM
JULY 28, 1994

Federalism and Health Care Reform -- A Path Almost Ignored

At this point in the national debate over health care reform, a half-dozen plans have come to the forefront. All of them seem to have obtained negative majorities. They have a common and, I believe, flawed premise. It is that the road to national health reform is a single, national, one-plan-fits-all model.

This path has taken many forms: managed competition, single-payer, employer or individual mandate, pay-or-play, Medicare expansion, market reform. The path has been trampled by detail and controversy over the means supporters use. This trampling has almost buried the broad agreement on the necessity of achieving universal coverage and cost containment.

A second path -- the path almost ignored -- is a decentralized structure, based on the principles of federalism, in which the federal government establishes objectives and states provide the specifics.

In such a system, the federal government would establish nationally agreed upon health care performance objectives, standards and goals, while giving states and communities the ability to develop localized tactics to achieve those standards. Such a structure would bring the decision-making process down to the state and community level, where health care markets are all very different.

Although several plans refer tangentially to a state role, national reform should establish a federal-state partnership as a central principle rather than an aside.

As the National Academy of Sciences's Institute of Medicine notes:

> "States are the principal governmental entity responsible for protecting the public's health in the United States. They conduct a wide range of activities in health. State health agencies collect and analyze information; conduct inspections; plan; set policies and standards; carry out national and state mandates; manage and oversee environmental, educational and personal health services; and assure access to health care for underserved residents; they are involved in resource development; and they respond to health hazards and crises."

Health care is particularly suitable to the establishment of national goals with decentralized implementation and sensitivity to local variations. States and communities within states have different health care needs based on societal factors such as:

1) The quantity and nature of health care providers. For example, Nebraska, North Dakota and South Dakota have twice the number of hospital beds per person as Alaska, New Hampshire and Hawaii.

2) Varying demographics, especially of the most health care intensive populations. For example, as a percentage of state

To: Chuck Konigsberg, Fax 8-3904 4-6698 — Beer
From: Ed Barron 542-7489
Counsel, Senate Agriculture, Nutrition and Forestry Committee
Date: June 17, 1994

Subject: Continued Sen. Jeffords Support for President's Health Care Bill

At Senator Leahy's instruction, I have been working with Chris Jennings and others at the White House, as well as with Senator Jeffords' staff, on one aspect of the health care bill -- mandatory full funding for WIC (the Special Supplemental Food Program for Women, Infants and Children).

Both Senators Leahy and Jeffords have had several discussions with the President on this full funding proposal which will cost around $1.9 billion in total over 5 years.

This was an easy sell to the President. In the campaign and in Putting People First the President promised full funding for WIC by FY 1996. This goal has broad bipartisan support on Capitol Hill. For example, it was a major recommendation of the Children's Commission chaired by Senator Rockefeller.

A GAO report requested by Senators Bumpers and Harkin found that each $1 invested in WIC saves $3.50 in reduced health care and related costs. In addition to reducing health care costs, WIC decreases infant mortality, low birthweight, child anemia, and the likelihood that newborns will be placed in neonatal intensive care.

Senator Jeffords, the only Republican member sponsoring the President's bill in the House and the Senate, has made it clear to the President that his support depended on guaranteeing that full funding. On Friday the President made available to the Vermont press a transcript of a conversation he had with Sen. Jeffords in which the President thanked Sen. Jeffords for getting the WIC language included in the Labor Committee reported bill. Senator Jeffords is up this year and this matter is crucial to him.

The WIC language is also in the reported bill of the House Education and Labor Subcommittee on Labor-Management relations.

FUNDING MECHANISM

The Senate and House bill language would add a total of $1.9 billion in fiscal year 1996 through 2000. This would be paid for through funds generated from "Pay-As-You-Go" savings in the health care reform bill. This $1.9 billion would not count against discretionary caps.

Under the bill, a strong incentive is established for Congress to appropriate specified "target" amounts for WIC each year. Those targets are: $3.660 billion in 1996, $3.759 billion in 1997, $3.861 billion in 1998, $3.996 billion in 1999, and $4.136 billion in the year 2000.

The approach establishes that if at least those discretionary amounts are appropriated, then (and only then) additional mandatory money will be provided for WIC to achieve full funding. These additional amounts ($254 million in 1996, $407 million in 1997, $384 million in 1998, $398 million in 1999, and $411 million in the year 2000) make up the difference between the appropriated "discretionary" amounts and full funding levels.

This approach also helps the appropriations committees, which have seen major cuts in the amount they have available to spend while at the same time are under pressure to fully fund WIC. The appropriations committees need only to meet the "target" amounts and will still be able to fulfill the President's promise of full funding for WIC. The target amounts should not be difficult for the Appropriations Committees to reach.

The Administration decided against simply mandating the payment of specified additional

possibility of the appropriations committee just reducing the amount they appropriated for WIC.

MODIFICATION TO ORIGINAL HEALTH SECURITY ACT LANGUAGE

There was one problem with the WIC provision as originally included in the Health Security Act. The contingency established that the mandatory amounts would be spent only if appropriations levels hit the specified "targets." If appropriators did not meet the target levels for WIC appropriations, the additional money could not be spent. Both OMB and CBO ruled that since the appropriations committee controlled whether or not the additional funds would be spent, both amounts would score as discretionary spending and count against the caps. To be scored as Pay-As-You-Go spending, the money must be allocated and spent regardless of what other action Congress takes.

The language as modified in the House Education and Labor subcommittee and the Senate Labor and Human Resources Committee specifies that if appropriations for WIC do not meet the "target" amounts, the amounts in the special fund would be spent on low income children in the school lunch program. This corrected the HSA problem by guaranteeing that the money would be spent regardless the WIC appropriations target was met.

Extensive meetings with OMB and CBO determined that this approach was the only way to ensure that the provision would be scored in the intended manner and achieve the goal of full funding for WIC. If the target amount is met or exceeded, the additional amounts will be spent on WIC to achieve full funding. If the target amount is not provided, school lunch reimbursements for free and reduced price meals would increase.

This way, the spending is not contingent on actions taken by the Appropriations Committee -- the money is spent no matter what level of appropriations is provided for WIC. This provision was included to satisfy budget rules -- we do not expect this scenario to come into play.

The language adopted continues to ensure that the mandatory funds would be provided in a manner that fully complies with Pay-As-You -Go rules and that, combined with other provisions in the HSA, it would not increase the deficit.

All interested parties, including Senator Jeffords, have signed off on this approach. This revised language has been reported out of the full Senate Labor and Human Resources Committee and the House Education and Labor subcommittee.

Everything on baseline

- who determines what the mandate is?

- who does it?

- Oren Rad Man,

THE WHITE HOUSE
WASHINGTON

Health Care Reform

Spending side:

+ New spending

- New deduction for uninsured & self-employed
- amount of vouchers paid for low income.
- a.

- excise tax on cigs
- assessment on large corp plans

Chris Wilson

THE WHITE HOUSE

WASHINGTON

Baseline written into statute

Reform

Medicare
Medicaid
- ~~[illegible]~~ Federal Health Care baseline

~~Subsidies~~

current deduction - (25% for self-employed)
employer A.T. 1/4 [illegible] [illegible]
cafeteria plan

estimate in what exclusion based?
(CBO current report)

(1) Current Federal Health Care Spending Baseline
~~[illegible]~~ written law 1993 CBO projections
[illegible] CBO most recent

(2) Spending line

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

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Number of Pages (Including Cover): 2

Comments: Happy Belated Birthday!

United States

Number of Firms, Establishments, Employment and Annual Payroll by Legal Form of Organization and Firm Size for 1991

Employment Size of Firm

	Total	0-24	25-49	50-74	75-99
FIRMS	5,051,025	4,642,171	223,104	70,313	33,122
ESTABS	6,200,859	4,734,562	282,767	113,238	66,204
EMPLOY.	92,307,559	21,184,366	7,606,640	4,229,557	2,838,660
ANNL PAYROLL ($1,000)	2,145,015,851	431,546,741	155,580,925	87,549,039	58,900,700

100-249	250-499	500-999	1000-2499	2500-4999	5000 +
53,468	14,870	6,842	4,362	1,366	1,407
164,150	96,445	81,740	110,405	82,319	469,029
8,027,967	5,115,423	4,715,151	6,701,359	4,709,394	27,179,042
169,420,799	110,016,099	107,065,336	161,582,065	120,210,338	743,143,809

SOURCE: Census, Dept Commerce

71.2%

185,750

United States Senate
Democratic Policy Committee

Washington, DC 20510-7050
(202) 224-5551

Room: S-118, The Capitol

Telephone Number: 202-224-5551

DATE: 6/21

TO: Chris Jennings

FAX #: 456-7431

FROM: Bob Cohen
224-5344

TOTAL NO. OF PAGES IN THIS TRANSMISSION (INCLUDING THIS PAGE): 5

If you do not receive all pages in this transmission, please contact: Nancy
224-4555

UNIVERSAL COVERAGE

The commission would report to Congress every 2 years on the demographics of the uninsured, and its findings on why those individuals were uninsured.

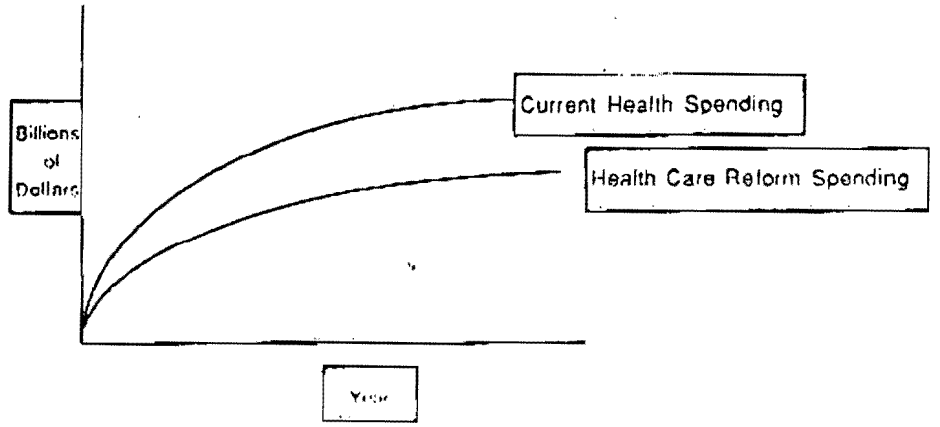
In the event 96% of all Americans do not have health insurance by 2001, the Commission will develop a package of recommendations to Congress designed to reach universal coverage. Special procedural provisions (similar to fast-track) would be included for fast consideration of this package.

If Congress failed to act on the Commission package or defeated it without enacting an alternative, an automatic "Free-Rider" penalty would be imposed upon:

- Individuals who do not procure coverage (a special provision will be included allowing childless individuals under 30 to purchase catastrophic coverage instead of the uniform benefit plan);

- *??? Businesses that do not provide insurance coverage ???*

AUTOMATIC FAIL-SAFE BUDGET PROTECTION PROCESS



Current Baseline Health Spending Estimates Include:

- Medicare
- Medicaid
- Tax Spending
  - Employer Provider Health Insurance to Employee
  - Cafeteria Plans

Health Care Reform Spending Estimates Include:

- Medicare (including reductions)
- Medicaid (including reductions)
- Tax Spending
  - Employer Provided Health Insurance to Employee
  - Expanded Deduction for Individually Purchased Insurance
  - Cafeteria Plans
- New Revenues for Health Care (i.e., cigarette tax)
- New Entitlement Spending (Subsidies)

In any year, if health care reform spending would exceed the current baseline health spending, the following automatic actions (each set to contribute a designated amount of the shortfall) will occur to prevent deficit spending:

1. Increased tax on high cost insurance plans
2. Subsidies to purchase insurance slowed down
3. Expanded tax deduction phase-in slowed down
4. Out-of-Pocket limit increased for health insurance
5. *??Medicare??*

TAX CAP SUBSTITUTE
AND ALTERNATIVE APPROACH TO CAPS ON PREMIUMS

PURPOSE: To retain the economic incentives of a tax cap -- allowing a high degree of individual choice of plans, but imposing a limit on how much the government will subsidize; and to impose a penalty on higher cost insurance plans.

1. A Commission will be established to evaluate health care spending and market trends in areas throughout the country. The Commission will study how the competitive market works in high and low cost areas and will make recommendations to Congress on changes in health care reforms to reflect its findings. It will establish performance measures to determine whether market reforms are effective in holding down the rate of growth in health care costs in individual market areas.

2. An assessment will be placed upon high cost insurance plans. A high cost plan is one that exceeds the average of the lowest cost two-thirds of plans offered in an area. A plan above the two-thirds average will be subject to a 25% premium tax on the difference between its premium and the average. (Working on rule for rural and frontier areas.)

3 A plan offered in an area where the average exceeds the National average will be subject to an additional tax if it cost is above the two-thirds average and its rate of increase is above an inflation factor set in the statute.

4. Applies to all health plans including self-insured.

FINANCING
(Estimated 5 year financing, $ in billions)

Medicare Cuts	
Change Hospital Inpatient Update Formula	$13.8
Hospital Inpatient Capital	6.7
Phase Down Hospital DSH	13.2
Reduce Hospital IME	14.1
Extend OBRA 93 SNF Savings	0.8
MD Fees: Real Per Capita GDP	5.1
MD Fees: Cumulative Targets	15.3
MD Fees: Conv Factor	2.5
Income-Related Premiums	8.0
Extend 25% Part B Premiums	4.9
Extend OBRA 93 Home Health	2.2
10% Home Health Copay	7.6
Extend Secondary Payor	3.7
Home Health Median Limit	1.5
Part B Deductible	1.5
Interaction effects	-15.2
Subtotal Medicare	$86.0
Medicaid Cuts	
Medicaid DSH Phase-down	$43.7
Medicaid Capitation	12.0
Subtotal Medicaid	$55.8
Postal Service Retirement	$13.0
Subtotal Spending Reductions	$154.7
Revenues	
Premium Assessment	$37.5
Tobacco Tax	$54.0
HI State/Local	7.6
Subtotal Revenues	$61.6
TOTAL FINANCING	$253.8

****

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SIZE	# FIRMS (millions)	% FIRMS	# WORKERS (millions)	% WORKERS	% FIRMS HLTH BEN	% WORKERS HLTH BEN	% FIRMS SELF INS	%WORKERS SELF INS
1-50	4.27	95.8%	29.0	31.2%	32.8%	50.4%	3.6%	5.1%
1-100	4.37	98.1%	36.1	38.8%	34.1%	57.4%	3.7%	5.8%
1-250	4.43	99.3%	44.2	47.5%	34.8%	64.0%	4.0%	9.1%
1-500	4.44	99.7%	49.3	53.1%	35.0%	67.2%	4.1%	12.7%
1-1000	4.45	99.8%	54.1	58.2%	35.1%	69.8%	4.2%	16.1%

If from Census Consistent w/ HHS

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 2

(Mandate in 2002, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-24.6	-35.7	-41.0	-45.6	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-19.1	-23.4	-25.5	-27.7	-30.1	-32.7	-35.5	-38.6
3 Disproportionate Share Hospital Payments	0	0	-8.6	-10.2	-11.3	-11.6	-16.6	-20.7	-22.9	-25.2
4 Offset to Medicare Prescription Drug Program	0	0	0	0.0	0.0	-0.9	-2.0	-2.2	-2.5	-2.8
5 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total, Medicaid	0	0	-52.6	-70.0	-78.3	-86.6	-102.6	-113.3	-124.7	-137.1
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0.0	-1.1	-1.4	-1.5	-1.7	-1.8	-2.0	-2.2	-2.5
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.8	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Prohibition of Balance Billing	a	a	a	a	a	a	a	a	a	a
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.7	0.8
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Permanent Extension of 25% Part B Premium	0	0.8	0.9	1.3	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 2

(Mandate in 2002, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.6	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	*	*	0	0
Risk Contracts (Waive 50/50 Rule)	*	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	0	7.6	19.1	21.3	23.7	26.4
Total Medicare	2.4	6.7	10.3	14.3	21.2	21.5	16.4	22.5	28.9	35.6
Other Health Programs										
12 Vulnerable Hospital Payments	0	0	0	0	0	1.3	1.3	1.3	1.3	1.3
13 Long Term Care Program (capped at $46B)										
14 Home and Community Based Care	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
15 Life Care										
16 Academic Health Centers	0	0	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
17 Graduate Medical and Nursing Education	0	0	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
18 Medicare Transfer - Graduate Medical Education	0	0	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
19 Medicare Transfer - Indirect Medical Education	0	0	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
20 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	0.6	0	0	0
Total Other Health Programs	0	0.3	4.8	8.8	11.5	14.8	17.1	20.3	24.6	29.4
Subsidies										
21 Persons between 0-200% of Poverty before Mandate	0	0	46.2	67.1	75.1	84.1	94.2	24.2	0	0
22 Persons between 0-200% of Poverty after Mandate	0	0	0	0	0	0	0	147.6	211.9	233.2
23 Employer Subsidies (12 Percent)	0	0	0	0	0	0	0	51.7	76.7	87.8
24 Pregnant Women and Kids 0-240% of Poverty	0	0	15.6	22.3	24.3	26.5	28.6	7.3	0	0
25 Temporarily Unemployed	0	0	4.5	6.5	7.1	7.7	8.3	2.3	0	0
26 Presumptive Eligibility										
Total Subsidies	0	0	66.3	95.9	106.5	118.3	131.1	233.0	288.6	321.0

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 2

(Mandate in 2002, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

	MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
	Public Health Initiative										
27	Biomedical and Behavioral Research Trust Fund										
28	Health Services Research	a	0.2	0.3	0.5	0.6	0.6	0.6	0.6	0.6	0.7
29	PHS Core Functions	0.1	0.2	0.3	0.4	0.5	0.6	0.6	0.7	0.7	0.7
30	Health Promotion/Disease Prevention	0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
31	Development of Community Health Groups	0	0.2	0.4	0.5	0.4	0.3	0.2	0.2	0.2	0.2
32	Investment in Infrastructure Development (Loans)	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
33	Supplemental Services Grants	a	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
34	Enabling Grants	0	a	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5
35	National Health Service Corps	0	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3
36	Mental Health/Substance Abuse Grants	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
37	School Health Grants	a	0.1	0.2	0.4	0.5	0.6	0.7	0.7	0.7	0.8
38	Occupational Safety/Health Grants	0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
39	Indian Health Service	0	0	1.4	1.5	1.6	1.8	1.9	2.1	2.2	2.4
	Total - Public Health Initiatives	0.1	1.2	3.6	4.4	4.8	5.2	5.5	5.8	6.0	6.3
	MANDATORY OUTLAY CHANGES	-2.1	-5.1	11.7	24.0	23.4	30.3	34.5	123.5	165.5	183.9
	DISCRETIONARY OUTLAYS										
	Administrative Expenses										
39	Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
40	Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	2.0	2.0	2.0
41	Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
	Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	3.1	3.1	3.2
	Studies, Research, Demonstrations, Other										
40	Department of Labor Programs	a	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
41	Women, Infants, and Children	3.0	3.4	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2
42	EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
	Total Studies, Research, Demonstrations, Other	3.0	3.7	3.8	3.9	3.9	4.0	4.1	4.2	4.3	4.4
	DISCRETIONARY OUTLAY CHANGES	3.6	5.0	5.4	5.2	4.9	7.0	7.2	7.3	7.4	7.6
	TOTAL OUTLAY CHANGES	1.5	-0.1	17.0	29.2	28.3	37.3	41.8	130.8	172.8	191.5

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(By fiscal year, in billions of dollars)

MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
43 Increase in Tax on Small Cigarettes	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
44 1.75% Excise Tax on Private Health Ins Premiums	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
45 Addl Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
46 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
47 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
48 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
49 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
50 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
51 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
52 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
53 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	a	a	a	a	a	a	a	a	a	a
54 Tmnt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
55 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
56 Remove $150 million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
57 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2
58 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
59 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 2

(Mandate in 2002, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
60 Post-Retirement Medical/Life Insurance Reserves	---------- Negligible Revenue Effect ----------									
61 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
62 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
63 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
64 Disclosure of Return Information to State Agencies	---------- No Revenue Effect ----------									
65 Impose Premium Tax with Respect to Certain High Cost Plans	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
66 Limit Exclusion for Employer-Paid Health Benefits	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
67 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL RECEIPT CHANGES	**0.7**	**4.2**	**7.3**	**8.5**	**10.3**	**10.7**	**10.8**	**11.2**	**11.9**	**13.0**
DEFICIT										
MANDATORY CHANGES	**-2.6**	**-9.3**	**4.4**	**15.5**	**13.1**	**18.6**	**23.7**	**112.3**	**153.6**	**170.9**
TOTAL CHANGES	**0.6**	**-4.3**	**9.7**	**20.7**	**16.0**	**26.6**	**30.8**	**119.6**	**160.9**	**178.5**
CUMULATIVE DEFICIT EFFECT	**0.6**	**-3.5**	**6.3**	**26.9**	**44.9**	**71.5**	**102.3**	**221.9**	**382.8**	**561.3**

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The budgetary treatment of mandatory premium payments is under review.

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

3:00 7/29 DRAFT - Comments to JM

B. ADDITIONAL SUBSIDIES FOR UNINSURED KIDS

1996

1. **Eligibility:** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Infants who are currently covered to 133 percent of poverty, with an option to 185 percent of poverty, would be covered up 185 percent of poverty.

   b. Children up to age 6 who are currently covered up to 133 percent of poverty would be covered up to 185 percent of poverty.

   c. Children between ages 6 and 19 who are currently covered up 100 to percent of poverty on a phased-in basis would be covered up to 185 percent of poverty.

   d. Children who are currenlty covered up to 185% of poverty through 1902(r)(2) or 1115 waivers will be covered. States that use 1902(r)2 or 1115 waivers to cover children at higher income levels could continue to cover these persons at current FFP, but would receive 100% Federal financing only for children with income up to 185 percent of poverty.

2. **Coverage through Private Plans:** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, State options include:

   a. Family option of employer plan: a state may elect to enroll children in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll the children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll the children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d. A state may elect to enroll children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only ~~for the services covered by Medicaid~~ for Medicaid covered services carried under a State's

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans for those who are in the states' Medicaid eligible groups prior to the 1996 expansion. State plan prior to 1996.

3. **Financing:** The Federal government would provide the following Federal matching through Medicaid.

a. All current eligibility categories would continue to matched at the state's regular Medicaid matching rate (FMAP), except as noted below.

1. Coverage for infants with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

2. Coverage for children up to age 6 with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

3. As of 1/1/96, coverage for children born before 10/1/83 up to age 19 (children ages 14 through 18) with family incomes above AFDC but below 100 percent of poverty would be 100 percent Federally financed.

4. Coverage for children age 6 up to age 19 with family incomes between 100 percent and 185 percent of poverty would be 100 percent Federally financed.

5. Coverage for children above 185 percent of poverty in states that expand eligibility through 1902(r)(2) or 1115 waivers would continue be matched at the states' FMAP.

b. Administrative costs would continue to be matched as in current law.

1997 And Subsequent Years

1. **Eligibility:** In general, children up to age 19 who have not been covered by private health insurance for at least six months (or longer if dropping employer coverage is an issue) and who are in families with incomes up to 240 percent of poverty would be eligible for a voucher toward insurance coverage.

   a. Children in a family would not be eligible for this program if the children are eligible for coverage under an employer's plan where the employer offers to contribute at least 80 percent (could make it a lower level if there would be an assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a single-parent or two-parent family policy.

   b. To be eligible for the program, families would be required to enroll all eligible dependent children.

   c. Children who were covered under a state's Medicaid program (cash or noncash) as of December 1996 would not be required to meet the six month previously-uninsured test.

2. **Amount of Subsidy:**

   a. Eligible children in families with income up to 185 percent of poverty would receive a voucher for the full premium for the appropriate children's policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA).

   b. Eligible children in families with incomes between 185 percent and 240 percent of poverty would receive a voucher for a portion of the premium (calculated on a sliding scale, phasing out at 240 percent of poverty) for the appropriate children's policy (limited as in a. above).

3. **Use of subsidies:** Community-rated health plans would accept vouchers toward payment of coverage.

   a. Community-rated health plans would create two categories of children's coverage: single child and multiple child.

   b. These categories would be tied to the premiums charged for two-parent family coverage. The National Board (or HCFA) would determine the average cost of insuring children and would express it as a national percentage for family coverage. For example, the single child policy might be one-third of the premium for the two-parent family policy and the multiple child policy might be one-half of the two-parent family premium.

c. Eligible children with a parent covered by a community-rated or experience-rated plan could use their voucher to be covered under the parent's policy.

4. **Nondiscrimination:** To protect the subsidy program from the incentives for employers to drop coverage (and/or contributions) for dependent children, nondiscrimination rules would apply to employer's decisions to offer coverage and the percent they contribute for dependent children. Nondiscrimination rules would apply by class of employee (i.e. full-time or part-time).

5. **Multiple Eligibility:** For families that are eligible for a subsidy under the kids program and under the low income or unemployed voucher program:

   a. The family would receive the sum of: the voucher amount for the kids and the applicable low-income (or unemployed) voucher amount for the family.

   b. The voucher for the low income voucher program would be calculated using the poverty level based on the entire family, but the premium would be the applicable premium for the entire family minus the premium applicable for the kids alone.

   c. A family may use the children's voucher and the low-income voucher to purchase separate policies or combine their value toward one policy.

   d. (see page 8)

6. **Wrap-around Benefits:** Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services). These benefits are limited to the recipient eligibility groups set by the states prior to the expansion.

(*) A children's voucher could be [redacted] combined with any contribution provided by a parent's employer, so long as that contribution does not exceed 90 percent of the premium.

C. ADDITIONAL SUBSIDIES FOR PREGNANT WOMEN

1996

1. **Eligibility:** Medicaid coverage would be expanded as follows for the one-year period between 1/1/96 until 1/1/97:

   a. Pregnant women who are currently covered to 133 percent of poverty, with an option to 185 percent, would be covered up 185 percent of poverty.

   b. Pregnant women who are currently covered up to 185% of poverty through 1902(r)(2) or 1115 waivers would be covered. States that use 1902(r)2 or 1115 waivers to cover ~~children~~ pregnant at higher income levels could continue to cover these persons at current FFP, but would receive 100% Federal financing only for pregnant women with income up to 185 percent of poverty.

   c. As under current Medicaid law, pregnant women who would otherwise lose Medicaid eligibility due to a change in income remain Medicaid-eligible throughout their pregnancy and ~~three-month post-partum period~~ a sixty-day post-partum period.

2. **Coverage through Private Plans:** Pregnant women would be entitled to the Medicaid benefits ~~beyond pregnancy-related services~~ as determined by the states. Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a. Family option of employer plan: ~~A~~ a state may elect to enroll pregnant women in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll pregnant women in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll pregnant women in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d. A state may elect to enroll pregnant women in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid in that state.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services) for those who are in the states' Medicaid eligible groups prior to the 1996 expansion.

3. **Financing:** The Federal government would provide the following Federal matching through Medicaid.

a. All current eligibility categories would continue to matched at the State's regular Medicaid matching rate (FMAP), except as noted below.

1. Coverage for pregnant women with family incomes between 133 percent and 185 percent of poverty would be 100 percent Federally financed.

2. Coverage for pregnant women above 185% of poverty (percent) in states that expand eligibility through 1902(r)(2) or 1115 waivers would continue be matched at the states' FMAP.

b. Administrative costs would continue to be matched as in current law.

1997 And Subsequent Years

1. **Eligibility:** In general, uninsured pregnant women who are in families with incomes up to 240 percent of poverty would be eligible for a voucher toward insurance coverage.

a. Pregnant women would not be eligible for this subsidy if they have available an employer's plan where the employer offers to contribute at least 80 percent (could make it a lower level if there would be an assumption that employers would reduce coverage for dependents; note nondiscrimination rule!) toward the cost of a policy covering the women.

b. Eligibility would continue for ~~three months~~ 90 days after delivery.

c. Pregnancy would not be treated as a pre-existing condition.

d. ~~Medicaid (or CHAMP)~~ pregnant women who would otherwise lose ~~Medicaid~~ eligibility due to a change in income remain ~~Medicaid~~ eligible throughout their pregnancy and ~~three-month~~ post-partum period.

Expand criteria: Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services). These benefits are limited to the recipient eligibility groups set by the states prior to the expansion.

2. **Amount of Subsidy:**

a. Eligible women in families with income up to 185 percent of poverty would receive a voucher for the full premium for a single policy (limited to the lower of the weighted average community-rated premium or the reference premium in the HCCA.)

b. Eligible women in families with incomes between 185 percent and 240 percent of poverty would receive a voucher for a portion of the premium (calculated on a sliding scale, phasing out at 240 percent of poverty) for the single policy (limited as in a. above).

3. **Use of Subsidies:** Community-rated health plans would accept vouchers toward payment for coverage. A pregnant woman could use the voucher toward the purchase of a single policy or toward the purchase of a couple, single-parent or two-parent policy, as appropriate.

4. ~~Dual~~ **Eligibility:** For families that are eligible for a subsidy under the pregnant women program and under the low-income voucher or unemployed program:

a. The family would receive the sum of: the voucher amount for the pregnant woman and the applicable low income (or unemployed) voucher for the family.

b. The voucher for the low-income program would be calculated using the poverty level based on the entire family, but the premium would be the applicable premium for the entire family minus the premium applicable for the pregnant woman alone.

c. A family may use the pregnant woman voucher and the low-income voucher to purchase separate policies or combine their values toward one policy.

d. A family eligible for the low income (or unemployed), pregnant woman, and kids subsidy programs would be treated in the same way as described above, except that the applicable premium for the low-income (or unemployed) voucher program would be the applicable premium for the entire family minus the premiums applicable for the pregnant woman alone and the kids alone.

The applicable premium for the low-income (or unemployed) voucher program could not be less than zero.

D. SUBSIDIES FOR PEOPLE LEAVING WELFARE FOR WORK

1998

1. **Policy:** To provide subsidies for people leaving welfare for work, the existing Medicaid transition benefit would be extended to cover eligible individuals for 24 months.

2. **Duration of Coverage:** Current law allows for a simple 6-month extension, and then a more complex second 6-month extension. We recommend eliminating the second extension and lengthening the first by 18 months to create a single 24-month transition benefit.

3. **Eligibility:** Currently, the two-phased extension terminates if the family no longer has a dependent child. In the health reform context, family policies are provided to various family configurations, not just to couples with dependent children. For this reason, as well as to provide additional work incentives, we recommend striking the "termination for no dependent child" provision.

   In addition to those who have been off of welfare for work for one year, those who are in their second year off of welfare for work and who are currently uninsured would be eligible for this program.

4. **Coverage through Private Plans:** Similar to the OBRA 1990 provision, states are required to purchase group health insurance coverage for Medicaid beneficiaries where cost effective as defined by the Secretary. In addition, state options include:

   a. Family option of employer plan: A state may elect to enroll a caretaker relative and dependent children in a family option within the option of the group health plans offered to the caretaker relative.

   b. Family option of state employee plan: a state may elect to enroll the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the state to state employees.

   c. Health Maintenance Organizations: a state may elect to enroll the caretaker relative and dependent children in a health maintenance organization in which fewer than half of the membership are eligible to receive medical assistance benefits. This enrollment option is in addition to any enrollment option that a state might offer with respect to receiving services through a health maintenance organization.

d. A state may elect to enroll the caretaker relative and dependent children in a basic state health plan offered by the state to individuals in the state otherwise unable to obtain health insurance coverage.

Medicaid will pay for the full premium and the full cost sharing amounts, but only for services currently covered by Medicaid.

Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans (wrap-around services).

5. **Financing:** The Federal government would cover 100 percent of the expense related to this expansion.

1997 And Subsequent Years

1. **Eligibility:** Welfare recipients who return to work would receive subsidized coverage for two years.

2. **Amount of Subsidy:** Instead of receiving Medicaid coverage, welfare recipients returning to work would receive a full premium subsidy for the entire family (i.e. the family would receive a low-income voucher as if it had income below 75 percent of the poverty level).

3. **Wrap-around Benefits:** Current Medicaid rules governing covered services and recipient eligibility would be retained to cover services not otherwise provided under private health plans.

In 1978, the Congress enacted section 125 of the Internal Revenue Code, which allows employers to set up so-called cafeteria plans for certain employee benefits. A cafeteria plan allows employees to choose to receive part of their compensation in the form of one or more nontaxable fringe benefits or in the form of taxable wages. The benefits may include an optional health insurance plan or choice of plans; out-of-pocket expenses for such items as medical and dental services, prescription drugs, and eyeglasses; and the employee share of the cost of health insurance provided by employers. The law excludes benefits for medically related items paid for through a cafeteria plan from employees' taxable income. As a result, employees with access to such a plan may pay for all or most of their medical costs with pretax dollars.

In general, people who purchase their own insurance directly cannot deduct the cost. Individuals may, however, deduct the portion of their health insurance premiums plus other medical expenses that exceeds 7.5 percent of their adjusted gross income. From 1987 to 1993, self-employed people could deduct 25 percent of the cost of their insurance premiums under section 162(l) of the Internal Reve-

Table 2.
Trends in the Primary Source of Health Insurance for the U.S. Population, 1980-1993

Source of Insurance	1980	1983	1987	1990	1993
			People (Millions)		
Employment-Based[a]	148.0	149.5	150.3	153.1	148.6
Individual	15.5	15.1	14.8	14.7	15.1
Medicare	24.0	25.9	28.7	30.5	32.6
Medicaid	11.5	12.4	14.0	14.6	20.5
None	24.2	26.6	31.0	33.4	37.4
Total	223.2	229.6	238.8	246.2	254.2
			Percentage of Population		
Employment-Based[a]	66.3	65.1	62.9	62.2	58.5
Individual	6.9	6.6	6.2	6.0	6.0
Medicare	10.7	11.3	12.0	12.4	12.8
Medicaid	5.2	5.4	5.9	5.9	8.1
None	10.8	11.6	13.0	13.6	14.7
Total	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office (CBO) estimates based on data from the March Current Population Surveys of the Bureau of the Census and other sources.

NOTES: CBO is currently revising its estimates of the distribution of insurance coverage. The estimates presented here are preliminary.

Numbers may not add to totals because of rounding.

a. Also includes coverage provided through the Department of Veterans Affairs.

• Has not rec'd BC

Key states
• ND - Dorgan/Conrad
• Neb - Exon/Kerrey
• NV - Bryan
• NJ - Lautenberg/Bradley
• WVa - Rockefeller
• Conn - Lieberman
• Louisiana - Breaux/Johnston
• Ala - Heflin
• SC - Hollings
• Va - Robb
• Del - Biden
• Colo - Campbell
• Calif - Feinstein

SENATE STATUS (7/14/94)

(Democrats and Senator Jeffords Only)

Solid Base	Core	Likeley
27 (27)	7 (34)	7 (41)
Akaka	Bumpers	Biden OK (DE)
Boxer	Byrd	• Campbell OK (Colo)
Bingaman	Feingold	• Deconcini OK (Ariz)
Daschle	Kerry	x • Dorgan* Yes? (ND)
Dodd	Mathews	x • Exon Yes (Neb)
Glenn	Sasser	x • Heflin Yes (Ala)
Graham	Wellstone	x x Robb (VA)
Harkin		**Good Chance**
Inouye		6 (47)
Kennedy		x • Baucus Yes (not ~~not~~)
Leahy		x Bradley (NJ)
Levin		x • Breaux* (La)
Metzenbaum		x • Conrad* Yes? (ND)
Mikulski		x • Hollings* Yes? (SC)
Mitchell		x • Kohl (Wisc)
Moseley-Brun		**Swing**
Moynihan		10 (57)
Murray		Boren NO
Pell		x • Bryan* NO (Nev)
Pryor		x • Feinstein Yes? (Calif)
Reid		x • Ford Yes
Riegle		x • Johnston* NO (La)
Rockefeller		Kerrey NO (Neb)
Sarbanes		x • Lautenberg* (NJ)
Simon		x • Lieberman* (Conn)
Wofford		x Nunn NO
Jeffords		x Shelby NO

* = Face-to-Face Meetings Held or to be Scheduled

THE WHITE HOUSE

WASHINGTON

July 31, 1994

MEETING WITH SENATOR HEFLIN

Date: August 1, 1994
Location: Oval Office
Time: 6:30 - 7:00 PM
From: Patrick J. Griffin

I. PURPOSE

- To acknowledge the difficulties Senator Heflin faces in his home state in supporting health reform, particularly should Senator Shelby -- as expected -- not support the bill.

- Noting his important vote with the Administration on the budget, to seek his support with another critical vote for your Presidency -- health care reform which achieves universal coverage.

- To illustrate your flexibility and willingness to compromise for a bill with universal coverage.

II. BACKGROUND

Senator Heflin is not particularly well-versed on issues of health care reform. However, in private meetings he has expressed some frustration at the seeming inability of Senators to work out the problems on this issue so they could get it done.

At public events in Alabama he has expressed support for the concept of universal coverage. He also noted that he did not know how that could be achieved without some kind of employer mandate. However, Senator Heflin does share the concern of many moderate and Southern members about the impact of the mandate on small businesses. He advocates folding in the health component of workers' compensation insurance as a way of ameliorating the impact of the mandate on small business.

One issue with which he is quite familiar and has definite views is tort reform. He opposes caps on damages as a means of malpractice reform.

III. PARTICIPANTS

The President
Senator Heflin
Patrick Griffin

IV. SEQUENCE OF EVENTS

Closed meeting with Senator Heflin in the Oval Office.

V. PRESS PLAN

Closed Press. (White House photographer will be present.)

THE WHITE HOUSE

WASHINGTON

SENATE STATUS (7/14/94)

[Democrats and Senator Jeffords Only]

Solid Base	Core	Likely	Good Chance	Swing
27 (27)	8 (35)	8 (43)	4 (47)	10 (57)
Akaka	Baucus	Biden	Bradley	Boren
Boxer	Bumpers	Campbell	Breaux*	Bryan*
Bingaman	Byrd	Deconcini	Feinstein	Conrad*
Daschle	Feingold	Dorgan*	Hollings*	Ford
Dodd	Kerry	Exon		Johnston*
Glenn	Mathews	Heflin		Kerrey
Graham	Sasser	Kohl		Lautenberg*
Harkin	Wellstone	Robb		Lieberman*
Inouye				Nunn
Kennedy				Shelby
Leahy				
Levin				
Metzenbaum				
Mikulski				
Mitchell				
Moseley-Braun				
Moynihan				
Murray				
Pell				
Pryor				
Reid				
Riegle				
Rockefeller				
Sarbanes				
Simon				
Wofford				
Jeffords				

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* = Face-to-Face Meetings Held or to be Scheduled

THE WHITE HOUSE

WASHINGTON

SENATE STATUS (7/14/94)
[Democrats and Senator Jeffords Only]

Solid Base	**Core**	**Likely**	**Good Chance**	**Swing**
27 (27)	8 (35)	8 (43)	4 (47)	10 (57)
Akaka	Baucus	Biden	Bradley	Boren
Boxer	Bumpers	Campbell	Breaux*	Bryan*
Bingaman	Byrd	Deconcini	Feinstein	Conrad*
Daschle	Feingold	Dorgan*	Hollings*	Ford
Dodd	Kerry	Exon		Johnston*
Glenn	Mathews	Heflin		Kerrey
Graham	Sasser	Kohl		Lautenberg*
Harkin	Wellstone	Robb		Lieberman*
Inouye				Nunn
Kennedy				Shelby
Leahy				
Levin				
Metzenbaum				
Mikulski				
Mitchell				
Moseley-Braun				
Moynihan				
Murray				
Pell				
Pryor				
Reid				
Riegle				
Rockefeller				
Sarbanes				
Simon				
Wofford				
Jeffords				

Scott Harrison:
CBO: 226 - 2820

Parashar (-2) - (-1)

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* = Face-to-Face Meetings Held or to be Scheduled

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

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NOTE TO JUDY FEDER AND JERRY KLEPNER

Ollie Fein of the Senate Majority leader's staff has requested technical assistance on the impact of a policy option for allocation of DME payments.

The Labor & Human Resource bill would phase hospitals over five years to a 50/50 blend of their Medicare all-payer costs and the wage adjusted national average per resident amount.

The alternative would allow hospitals to receive the higher of the adjusted national average or the blended amount in each year of the phase-in.

The attached draft tables show the impact of the alternative relative to the policy in the Labor & Human Resources bill. The first table shows the distributional impact if the alternative were implemented in a budget neutral fashion. The second shows the distributional impact and the additional cost of the alternative if it were not budget neutral.

If there are any questions regarding these tables, please call Kate Rickard at 690-5824.

7/29

Brian Biles

DME Comparison of Options[1] for 50/50
All–Payer Cost Based/Adjusted National Average Blend

Budget Neutral

	N	Year 1 90/10[2] Symmetric Transition	Year 1 90/10[2] Asymmetric Transition	Year 1 90/10[2] Percent Change	Year 2 80/20 Symmetric Transition	Year 2 80/20 Asymmetric Transition	Year 2 80/20 Percent Change	Year 3 70/30 Symmetric Transition	Year 3 70/30 Asymmetric Transition	Year 3 70/30 Percent Change	Year 4 60/40 Symmetric Transition	Year 4 60/40 Asymmetric Transition	Year 4 60/40 Percent Change	Year 5 50/50 Symmetric Transition	Year 5 50/50 Asymmetric Transition	Year 5 50/50 Percent Change
All Teaching Hospitals	1197	$5,800,000	$5,800,000	0.00	$5,800,000	$5,800,000	0.00	$5,800,000	$5,800,000	0.00	$5,800,000	$5,800,000	0.00	$5,800,000	$5,800,000	0.00
AMC	93	$1,799,866	$1,843,619	2.44	$1,806,828	$1,845,933	2.16	$1,813,865	$1,848,109	1.89	$1,820,976	$1,850,350	1.61	$1,828,166	$1,862,657	1.84
Non AMC COTH	173	$1,553,461	$1,514,740	-2.49	$1,545,068	$1,510,805	-2.22	$1,536,821	$1,506,755	-1.94	$1,528,085	$1,502,585	-1.67	$1,519,417	$1,498,690	-1.39
Non COTH	931	$2,448,673	$2,441,441	-0.21	$2,448,066	$2,443,262	-0.20	$2,449,514	$2,445,136	-0.18	$2,450,967	$2,447,066	-0.16	$2,452,418	$2,449,062	-0.14
Interns–Residents to Beds Ratio																
Low	657	$610,849	$611,579	0.15	$607,429	$608,510	0.18	$604,174	$606,361	0.19	$600,683	$602,099	0.20	$597,558	$598,749	0.20
Medium	313	$1,577,640	$1,533,958	-2.77	$1,570,752	$1,531,683	-2.47	$1,563,789	$1,529,750	-2.16	$1,556,751	$1,527,559	-1.88	$1,549,637	$1,525,291	-1.57
High	64	$869,063	$854,272	-1.70	$864,566	$851,568	-1.50	$860,020	$848,768	-1.31	$855,426	$845,921	-1.11	$850,761	$842,971	-0.92
Highest	143	$2,742,847	$2,800,199	2.10	$2,757,254	$2,806,039	1.84	$2,772,017	$2,816,114	1.59	$2,786,940	$2,824,427	1.35	$2,802,024	$2,832,969	1.11
Disproportionate Share																
High DSH	327	$3,060,810	$3,060,243	-0.02	$3,055,441	$3,055,334	-0.00	$3,050,014	$3,050,282	0.01	$3,044,529	$3,045,061	0.02	$3,038,984	$3,039,724	0.02
Other DSH	275	$1,267,306	$1,259,750	-0.60	$1,269,481	$1,262,504	-0.55	$1,271,679	$1,265,337	-0.50	$1,273,699	$1,268,254	-0.44	$1,276,144	$1,271,269	-0.38
Non DSH	595	$1,471,882	$1,480,007	0.55	$1,475,078	$1,482,162	0.48	$1,476,307	$1,484,361	0.41	$1,481,572	$1,488,665	0.34	$1,484,872	$1,489,017	0.28
Size																
Urban 0–99 beds	88	$53,589	$58,380	8.90	$54,559	$58,788	7.75	$55,540	$59,229	6.64	$56,531	$59,682	5.57	$57,533	$60,149	4.56
Urban 100–199 beds	256	$326,187	$330,846	1.43	$325,925	$330,146	1.30	$325,661	$329,425	1.18	$325,393	$328,684	1.01	$325,123	$327,919	0.86
Urban 200–299 beds	256	$707,669	$713,068	0.73	$709,518	$714,061	0.64	$711,164	$715,123	0.55	$712,808	$716,196	0.47	$714,571	$717,302	0.38
Urban 300–399 beds	221	$993,559	$1,013,154	1.97	$998,637	$1,014,258	1.75	$1,000,150	$1,015,393	1.52	$1,003,499	$1,016,569	1.30	$1,006,689	$1,017,767	1.08
Urban 400–499 beds	127	$947,604	$934,482	-1.39	$947,684	$935,772	-1.26	$947,673	$937,099	-1.12	$947,693	$938,466	-0.97	$947,652	$939,874	-0.82
Urban 500+ beds	176	$2,676,975	$2,659,349	-0.66	$2,673,109	$2,657,508	-0.58	$2,669,201	$2,655,613	-0.51	$2,665,251	$2,653,662	-0.43	$2,661,258	$2,651,652	-0.36
Rural 0–49 beds	10	$1,449	$1,713	18.19	$1,494	$1,729	15.67	$1,540	$1,745	13.30	$1,586	$1,762	11.07	$1,633	$1,779	8.95
Rural 50–99 beds	12	$2,240	$2,157	-3.66	$2,236	$2,162	-3.31	$2,232	$2,167	-2.93	$2,228	$2,172	-2.54	$2,225	$2,177	-2.15
Rural 100–149 beds	13	$4,045	$4,426	9.41	$4,126	$4,465	8.18	$4,211	$4,505	6.97	$4,296	$4,546	5.83	$4,381	$4,584	4.74
Rural 150–199 beds	13	$17,275	$16,333	-5.45	$16,751	$15,942	-4.83	$16,222	$15,539	-4.21	$15,687	$15,124	-3.58	$15,146	$14,696	-2.97
Rural 200+ beds	22	$69,117	$66,111	-4.35	$67,758	$65,150	-3.85	$66,386	$64,162	-3.35	$64,998	$63,144	-2.85	$63,595	$62,098	-2.36
Region																
New England	90	$454,376	$469,590	3.35	$459,177	$472,534	2.91	$464,030	$475,562	2.49	$468,935	$478,681	2.08	$473,894	$481,893	1.69
Mid Atlantic	269	$2,100,205	$1,997,625	-4.88	$2,076,934	$1,986,196	-4.37	$2,053,413	$1,974,435	-3.85	$2,029,638	$1,962,328	-3.32	$2,005,606	$1,949,664	-2.79
South Atlantic	150	$736,822	$725,486	-1.82	$735,279	$723,441	-1.61	$731,596	$721,330	-1.40	$727,674	$719,164	-1.20	$724,112	$716,930	-0.99
East North Central	249	$1,000,919	$992,220	-0.87	$1,003,464	$995,429	-0.80	$1,006,037	$998,732	-0.73	$1,008,656	$1,002,133	-0.64	$1,011,267	$1,005,606	-0.56
East South Central	53	$182,745	$189,155	3.51	$182,966	$188,746	3.15	$183,233	$188,330	2.78	$183,461	$187,900	2.41	$183,731	$187,457	2.03
West North Central	99	$288,956	$307,303	6.35	$292,082	$306,389	5.58	$295,242	$309,507	4.83	$298,435	$310,657	4.10	$301,664	$311,849	3.37
West South Central	106	$317,473	$329,636	3.83	$319,418	$330,238	3.39	$321,364	$330,857	2.95	$323,371	$331,495	2.51	$325,379	$332,152	2.08
Mountain	47	$136,071	$144,077	4.35	$139,396	$144,712	3.81	$140,736	$145,365	3.29	$142,090	$146,038	2.76	$143,459	$146,731	2.28
Pacific	131	$578,333	$644,806	11.51	$591,262	$650,313	9.99	$604,329	$655,877	8.53	$617,537	$661,606	7.14	$630,889	$667,506	5.80
Ownership																
Voluntary	954	$4,166,839	$4,142,757	-1.05	$4,176,600	$4,137,813	-0.93	$4,166,661	$4,132,726	-0.81	$4,156,408	$4,127,468	-0.70	$4,146,045	$4,122,094	-0.58
Proprietary	78	$89,843	$91,883	2.27	$89,825	$91,656	2.05	$89,808	$91,442	1.82	$89,786	$91,211	1.59	$89,769	$90,974	1.34
Govt–Urban	155	$1,600,265	$1,643,907	2.91	$1,591,485	$1,649,973	2.55	$1,582,606	$1,656,215	2.19	$1,594,248	$1,662,642	1.85	$1,545,815	$1,669,262	1.52
Govt–Rural	12	$23,033	$21,453	-6.86	$21,686	$20,548	-6.12	$20,727	$19,617	-5.36	$19,556	$18,656	-4.59	$18,372	$17,671	-3.82

[1] Option 1:
Symmetric Transition: Hospitals with historic cost based per resident amounts either greater or less than adjusted national average phased to 50/50 blend over five years.

Option 2:
Asymmetric Transition: Hospitals with historic cost based per resident amounts greater than adjusted national average phased to 50/50 blend over five years.
Hospitals with cost based amounts less than adjusted national average move to 50/50 blend in first year and subsequently.

[2] Blend is 90% all–payer cost based/10% adjusted national average in Year 1, 80% all–payer cost based/20% adjusted national average in Year 2, etc.

Based on the Medicaid drug pricing criteria requiring Medicare DSH percentage of over 11.75%. This includes both public and non–public hospitals.

DME Comparison of Options[1] for 50/50
All–Payer Cost Based/Adjusted National Average Blend

Not Budget Neutral

		Year 1 90/10[2]			Year 2 80/20			Year 3 70/30			Year 4 60/40			Year 5 50/50		
	N	Symmetric Change	Asymmetric Change	Percent Change	Symmetric Change	Asymmetric Change	Percent Change	Symmetric Change	Asymmetric Change	Percent Change	Symmetric Change	Asymmetric Change	Percent Change	Symmetric Change	Asymmetric Change	Percent Change
All Teaching Hospitals	1197	$6,800,000	$6,328,950	9.12	$5,800,000	$6,272,685	8.15	$5,800,000	$6,215,816	7.17	$5,800,000	$6,158,934	6.18	$5,800,000	$6,100,230	5.19
AMC	93	$1,799,668	$2,011,972	11.78	$1,806,826	$1,996,372	10.49	$1,813,865	$1,980,606	9.19	$1,820,978	$1,964,668	7.89	$1,828,168	$1,948,558	6.59
Non AMC OOTH	173	$1,553,461	$1,652,882	6.40	$1,545,088	$1,633,991	5.75	$1,536,621	$1,614,777	5.09	$1,528,065	$1,595,417	4.41	$1,519,417	$1,575,647	3.71
Non OOTH	931	$2,448,873	$2,664,097	8.88	$2,448,086	$2,642,382	7.94	$2,449,514	$2,620,434	6.96	$2,450,957	$2,596,249	6.01	$2,452,416	$2,575,624	5.03
Interns–Residents to Beds Ratio																
Low	557	$610,649	$667,354	9.29	$607,429	$658,101	8.84	$604,174	$648,750	7.39	$600,889	$639,298	6.39	$597,558	$629,743	5.39
Medium	313	$1,577,640	$1,673,851	6.10	$1,570,752	$1,656,728	5.47	$1,563,780	$1,639,421	4.84	$1,556,761	$1,621,929	4.19	$1,549,697	$1,604,246	3.52
High	64	$669,063	$692,180	7.26	$664,566	$920,969	6.62	$660,020	$909,637	5.77	$655,428	$898,184	5.00	$650,781	$886,606	4.21
Highest	143	$2,742,647	$3,055,569	11.41	$2,757,254	$3,036,887	10.14	$2,772,017	$3,018,007	8.87	$2,786,940	$2,998,925	7.61	$2,802,024	$2,979,035	6.34
Disproportionate Share																
High DSH	327	$3,060,810	$3,339,332	9.10	$3,055,441	$3,804,338	8.15	$3,050,014	$3,268,964	7.18	$3,044,529	$3,233,212	6.20	$3,038,984	$3,197,072	5.20
Other DSH	275	$1,267,308	$1,374,837	8.47	$1,269,481	$1,365,394	7.56	$1,271,679	$1,356,052	6.65	$1,273,899	$1,346,609	5.71	$1,276,144	$1,337,084	4.77
Non DSH	595	$1,471,662	$1,614,981	9.72	$1,475,078	$1,602,955	8.67	$1,478,307	$1,590,799	7.61	$1,481,572	$1,578,513	6.54	$1,484,872	$1,568,004	5.47
Size																
Urban 0–99 beds	88	$563,569	$663,693	18.84	$554,559	$683,579	16.53	$565,540	$663,475	14.29	$556,631	$669,369	12.10	$567,533	$663,263	9.96
Urban 100–199 beds	255	$326,187	$361,019	10.68	$325,925	$357,052	9.55	$325,661	$353,049	8.41	$325,393	$348,990	7.26	$325,123	$344,894	6.08
Urban 200–299 beds	256	$707,969	$778,098	9.92	$709,516	$772,276	8.85	$711,184	$766,392	7.76	$712,858	$760,444	6.67	$714,571	$754,432	5.58
Urban 300–399 beds	221	$993,569	$1,106,552	11.27	$996,637	$1,096,917	10.04	$1,000,150	$1,086,169	8.80	$1,003,499	$1,079,368	7.56	$1,006,683	$1,070,450	6.31
Urban 400–499 beds	127	$947,684	$1,019,706	7.60	$947,684	$1,012,035	6.79	$947,673	$1,004,282	5.97	$947,663	$996,446	5.15	$947,652	$988,525	4.31
Urban 500 + beds	178	$2,676,975	$2,901,678	8.40	$2,673,109	$2,874,066	7.52	$2,669,201	$2,848,000	6.62	$2,665,251	$2,817,610	5.72	$2,661,258	$2,786,912	4.80
Rural 0–49 beds	10	$1,449	$1,866	28.98	$1,494	$1,869	26.10	$1,540	$1,870	21.43	$1,586	$1,871	17.93	$1,633	$1,871	14.59
Rural 50–99 beds	12	$2,240	$2,354	5.11	$2,296	$2,398	4.57	$2,232	$2,322	4.03	$2,228	$2,306	3.48	$2,225	$2,289	2.92
Rural 100–149 beds	13	$4,045	$4,629	19.39	$4,128	$4,628	16.98	$4,211	$4,626	14.64	$4,296	$4,627	12.37	$4,381	$4,626	10.10
Rural 150–199 beds	13	$17,275	$17,523	3.17	$16,761	$17,241	2.92	$16,222	$16,653	2.66	$15,687	$16,059	2.37	$15,146	$15,457	2.05
Rural 200+ beds	22	$669,117	$672,140	4.37	$667,758	$670,460	3.99	$666,385	$668,782	3.58	$664,998	$667,045	3.15	$663,595	$665,311	2.70
Region																
New England	90	$464,376	$512,416	12.77	$459,177	$511,044	11.30	$464,030	$509,657	9.83	$468,935	$506,854	8.38	$473,894	$508,637	6.95
Mid Atlantic	269	$2,100,206	$2,179,605	3.79	$2,076,934	$2,148,066	3.42	$2,053,413	$2,115,987	3.05	$2,029,636	$2,083,562	2.66	$2,005,606	$2,050,786	2.26
South Atlantic	153	$736,922	$791,651	7.14	$735,279	$782,369	6.41	$731,596	$773,048	5.67	$727,874	$759,596	4.91	$724,112	$754,041	4.13
East North Central	249	$1,000,919	$1,082,709	8.17	$1,003,464	$1,078,554	7.26	$1,006,037	$1,070,304	6.39	$1,008,606	$1,064,048	5.49	$1,011,267	$1,057,691	4.59
East South Central	53	$192,745	$206,405	12.96	$192,988	$204,131	11.55	$193,233	$201,832	10.15	$193,481	$199,509	8.74	$193,731	$197,160	7.31
West North Central	99	$288,956	$335,320	16.05	$292,082	$333,522	14.19	$295,242	$331,696	12.35	$298,435	$329,850	10.50	$301,664	$327,985	8.75
West South Central	108	$317,473	$359,698	13.30	$319,416	$357,151	11.81	$321,384	$354,577	10.30	$323,371	$351,976	8.85	$325,379	$349,348	7.37
Mountain	47	$136,071	$157,216	13.67	$139,396	$156,505	12.27	$140,736	$155,787	10.59	$142,080	$155,060	9.13	$143,452	$154,326	7.57
Pacific	131	$578,333	$700,721	21.68	$591,282	$700,312	18.95	$604,329	$702,699	16.31	$617,637	$702,491	13.76	$630,669	$702,056	11.28
Ownership																
Voluntary	954	$4,166,809	$4,520,569	7.97	$4,176,803	$4,475,034	7.14	$4,186,661	$4,429,011	6.30	$4,196,406	$4,382,492	5.44	$4,146,045	$4,335,469	4.57
Proprietary	76	$89,843	$100,263	11.60	$89,625	$99,136	10.37	$89,806	$97,998	9.12	$89,786	$96,847	7.88	$89,769	$95,683	6.59
Govt–Urban	168	$1,500,265	$1,684,709	12.29	$1,511,485	$1,678,292	10.90	$1,522,808	$1,667,784	9.52	$1,534,248	$1,659,185	8.14	$1,545,815	$1,650,498	6.77
Govt–Rural	12	$23,033	$23,409	1.63	$21,868	$22,222	1.54	$20,727	$21,023	1.43	$19,556	$19,811	1.30	$18,372	$18,565	1.16

[1] Option 1:
Symmetric Transition: Hospitals with historic cost based per-resident amounts either greater or less than adjusted national average phased to 50/50 blend over five years.

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Based on the Medicaid drug pricing criteria requiring Medicare DSH percentage of over 11.75%. This includes both public and non–public hospitals.

Net New Federal $ per newly insured person

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline uninsured	38.3	38.8	39.3	39.5	39.9	40.4	41.1	41.9	42.6	43.3	44
Net Newly insured											
HSA	0	0	5.9	15.8	39.9	40.4	41.1	41.9	42.6	43.3	44
7.18.c	0	0	0	17.5	21.5	21.6	22.5	20.8	18	16	12.4
Subsidies											
HSA	0	0	11	37	98	121	128	144	164	181	197
7.18.c	0	0	0	66.2	113.5	119.9	128.0	123.1	117.4	112.2	105.1
Medicaid savings + State MOE											
HSA	0	0	4	16	44	66	74	83	93	104	116
7.18.c	0	0	0	45.7	80.8	89.9	99.9	110	120.5	131.4	143
Net new Federal $ per newly insured persons											
HSA	0	0	1187.45	1329.11	1353.38	1361.39	1313.87	1455.85	1666.67	1778.29	1840.91
7.18.c	0	0	0.00	1170.62	1521.89	1390.56	1247.96	630.02	-170.38	-1201.53	-3059.67

PRELIMINARY

7/29

4:55 p.m.

CHRIS:

Lisa Nolan wanted the following info:

When the mandate comes in (here assuming 2000), how many would receive coverage due to the employer mandate provisions and how many would receive coverage under the individual mandate provisions?

Answer: About 80% of the under 65 population through the ER mandate (about 185 million) and the remained (about 52 million) would be covered through the individual mandate (nonworkers, remaining uninsured in firms under 25).

Len also has this info---may want to check to see if he agrees.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To CHRIS	From KEN
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION